Montana Cannabis Information Association

MTCIA

March 24, 2018
Interim Committee on Children and Families
Re: Medical Marijuana Program
Contact: Kate Cholewa, Government Relations

The primary regulatory mechanisms are not being implemented in a way that will make them serve the purpose they are supposed to serve.

Goals of the legislation: a program that is transparent, contained, functional, and safe. The process was methodical implementation and phase-in regulatory mechanisms. The initiative gave the department 8 months to put the regulatory mechanisms of the initiative in place, licensing and inspection. The legislation gave the department a year to institute tracking and testing. Licensing and inspections created the foundation for tracking and licensing.

Goals of the department: get something up and going by the April implementation date, which isn't to say they don't want it to be transparent, safe, etc. But wanting it to be and building it to be are two different things. Because the program and new law were neglected for a year, the

effort since January is to do over a year's worth of work in 14 weeks. There's no methodical phase-in, which was for the department's sake as much as anyone in the program.

We appreciate the department's rush. The worker tasked with saving the day has been on for less than three months. I believe this person can get this program up and going in an impressive timeline. But not in 14 weeks. You can't go from zero to a regulatory system for a novel industry and market in which every state has a different model in three months. I don't think that is a critical thing to say. I say, enable this competent person to succeed and thereby let the program succeed and the work of the legislature succeed.

Three Major Problems with the Implementation

Licensing by Square Footage/Canopy Tiers

The legislation forwarded a square footage, or "canopy," licensing model to manage and measure production. The goal was to license by the amount of sq. footage cultivated, or by tiers of square footage.

Legislative intent is clear on this issue. It was discussed in detail in hearings and work sessions, all of at which the department was present. In House Tax, a motion was made to change the licensing fees to $100 per patient. Rep. Adam Hertz, who carried the bill on the House floor, objected on the basis that the legislation was aimed at separating licensing from patient numbers. The committee discussed the matter and voted down the motion specifically for this reason. Legislative intent doesn't get much clearer.

Several difficulties in the rules would be resolved by implementing the tiered, square footage licensing. As is, a mechanism intended to contain and measure and limit production will not achieve those objectives.

Licensing Roll Out

Second, licensing is being rolled out is such a way that makes some providers accountable for following regulations up to 8 months before others, depending upon when one's current provider registration expires. This translates to tens of thousands of dollars one provider will have to expend while another has that money to invest in their business or "buy patients." It's costing one guy $40,000 more than another and that other can use the $40,000 he is saving to buy out the guy who must pay it and must go out of business as a result. So, someone loses their business not because they can't afford the mechanisms of regulation, but because they can't afford them when they guy the down the street doesn't have to pay them, too.

The tracking system can still be implemented as people get licensed but recognized as a shakedown period where though one participates in the system, other than gross violations, it doesn't "count" until all licensees are on-board.

Testing

Attached you will find the MTCIA's response to the proposed rules in terms of needed regulation of the labs in order that the testing provision is meaningful. It's too expensive to be allowed to be snake oil or throw a monkey wrench into the entire program. A state license implies state sanction. It's a commitment to the people of Montana that the testing is giving people meaningful information.

There is no way there will be a lab system with the capacity to serve the demand by April 10. Throughout the entire session, the conversation around labs stressed the importance of labs to be available, affordable, and standardized. They are not available. They are not standardized. I'm not sure there's enough clarity yet to determine the affordability issue.

We advocated testing. But we need an accountable, responsible, credible lab component.

We can learn from giant, well-publicized disasters in other states who have had their systems backed up for 3 months due to issues with testing labs. Being backed up in a recreational market is bad enough. It's not acceptable in a medical one.

Example: Square Footage Licensing Model

In the tiers below, patient numbers are used to provide perspective on production capacity per provider per patient. However, patient numbers alone do not determine what tier any given provider must or should apply for.

For example, a provider with 10 patients all using a highly concentrated product can apply for tier two if the tracking system demonstrates that that level of production is necessary to serve the provider's cardholders. Of course, this provider would need to pay the licensing fee associated with that tier.

Likewise, a highly efficient grower can apply for as low of a licensing tier as possible to serve their cardholders.

A key driving force behind the licensing should be to incentivize efficiency and assure the ability to produce enough to serve cardholders.

Again, the use of patient numbers is only to create a reference. Any provider can apply for any tier. However, with the exception of tier 1, they must cultivate at least 75% of their allowance and be able to demonstrate via the tracking system that the tier is appropriate for what they are distributing.

Tier one

100 sq. ft or less

$1000

$10/sq. ft

392 providers with 10 cardholders or less

10 patients = 10 sq. ft/patient

5 patients – 20 sq. ft/patient

Revenue est: $392,000

Total possible canopy: 39,200 sq. ft

Tier two

101 – 450 sq. ft

$2500

$25 - 5.55/sq. ft

144 providers with 11-60 cardholders

11 patients = 41 sq. ft/patient

60 patients = 7.5 sq. ft/patient

Revenue est: $360,000

Total possible canopy: 64,800 sq. ft

Tier three

451 - 900 sq. ft

$3300

$7.30 - 3.66/sq. ft

27 providers with 61-130 cardholders

61 patients = 14.75 sq. ft/patient

130 patients = 7 sq. ft/patient

Revenue est: $89,100

Total possible canopy: 24,300 sq. ft

Tier four

900 - 1500 sq. ft

$4100

$4.55 - 2.73/sq. ft

28 providers with 130-240 cardholders

130 patients = 11.5 sq. ft/patient

240 patients = 6.25 sq. ft/patient

Revenue est: $114,800

Total possible canopy: 42,000 sq. ft

Tier five

1500 – 5000 sq. ft

$5000

$3.33 - 1/ sq. ft

19 providers with 271 + cardholders

300 patients = 16.7 sq. ft/patient

1500 patients = 3.33 sq. ft/patient

Revenue est: $95,000

Total possible canopy: 95,000 sq. ft

Total revenue: $1,050,900

Suggested parameters:

Must cultivate 75% of canopy allowance. An exception may have to be made for tier 1 as those providers with 2 or 3 patients should have no reason to cultivate that much space. However, this does call for monitoring by the department and tracking system to avoid diversion at the level of the smallest providers.

If, based on the numbers above, every provider grew out every sq. ft licensed for, the state would have a state canopy of 265,300 square feet. Of course, most won't grow out their entire allowance, or if they do, it will be because they are licensed to a lower tier than a less efficient grower and thus serving more cardholders out of less space. Based on the strictest calculation using the available formulas, this canopy would allow for 3-4x more production necessary to serve a cardholder base of 30,000. This gives room for trial and error and while if demonstrated to be too high can be more readily reigned in than the 50 sq. ft/patient model which provided more than 10x the needed canopy for the state. In addition, if the highest tier was determined to be insufficient to adequately supply a provider's cardholders' needs, and this was supported by the tracking system, the department could raise the ceiling via rule.

All indications are that next legislative session, patients will no longer be tethered to providers. Under those circumstances, it is impossible to license according to patient numbers. Shifting to tier-based licensing now not only serves the goals of allowing production calculations within the

program and avoiding overproduction and diversion, it saves the department the work of completely remodeling the licensing system within a year of creating it.

License and Inspections

The MTCIA continues to hold the position that the department needs to make licensing and inspecting the priority and first actions as originally dictated by the initiative in Nov 2016.

We have heard the department discuss the number of phone calls received with policy input and questions. We have heard them talk about doing "listening tours" or touring select facilities. A lot of time could be saved by rather than taking in input on the phone from parties one knows nothing about, the department could get the inspectors out in the field with a clipboard or computer and 5 critical criteria such as, Is there any product clearly from out-of-state present? Are there concentrates available when the provider does not have a certification to manufacture them? Are there any obvious safety concerns on the premises?

The inspector can also ask 5 key questions the department is interested in gathering data on and make note of general impressions. The department will learn a lot more by getting in the field than trying to build a regulatory model based on a contractor's tracking system and calls from individuals about whom they know nothing. While talking to other states and reviewing their rules is certainly of value, it can also be misleading as every state has a different model and it isn't always clear whether or not that model is a functional one. Imagine if another state looked at Montana's law in 2012 and assumed it would serve as a model to draw from just because it existed!

For more information, contact Kate Cholewa, MTCIA Government Relations, 406.459.4092

Medical Marijuana Program Provisions and Goals: The initiative and legislation, the rules, and what now?

Provision	Legislation/Legislative Intent	Rules	What now?
Canopy (Square footage) licensing	Enable determination of production levels Licensing untethered from patient numbers Deter overproduction and diversion	Allows 50 sq ft/patient Allows for >10x the needed production in the state = overproduction & diversion No way to calculate production No cap on production	Create licensing tiers that allow licensing by sq footage.
Licensing and Inspections	Required by the initiative. Foundation for tracking and testing in legislation (but was never implemented) Competitive market	All regulatory mechanisms being implemented simultaneously and/or out of implicit order causing messy implementation model. Phasing in licensing creating unfair advantages for those who do not have to be accountable for compliance until up to 8 mos after others	Follow implementation plan from initiative and legislation. License and inspect as priorities. Move licensees onto tracking system for a shakedown period of working out bugs& detecting gross violations.
Testing	Not intended to wipe out all but the largest providers. Standardized, affordable, available	No performance standards. No proficiency standards. Mandate implemented before services are available and beta-tested for capacity. Lack of clarity with protocols.	Develop performance standards. No mandate until system functioning.